14437

| 1. PLACE OF DEATH a. COUNTY ST. MA | | MADV | LAND MARYLAN | o. STATE | | eceosed lived, if institution b. COUN | | ore odmissio | on) |
|--|---|-----------------------------|------------------------|--|----------------|---------------------------------------|-------------------|--------------|---------|
| b. CITY OR TOWN write RURAL | (If outside corporate limit and give nearest town) | | c. LENGTH OF STAY IN 1 | c. CITY OR TOWN (I | f outside co | rporote limits, write RUR | | est town) | , |
| LEONARI | PITAL OR INSTITUTION (If no | at in hospital a | ive street address) | d. STREET ADDRESS | MOTON | TARK | | e. IS RESID | DENCE |
| | RY.S HOSPIT | | 110 311001 additoss) | BOX 313 | 8 LE | XINGTON PAR | K Md. | ON A FA | ARM? |
| 3. NAME OF DECEASED (Type or print) | JOSEPH | rst SB | Middle | BARNES | 4. D/ | | 28 | y Yeo | |
| S. SEX | 6. COLOR OR RACE | | NEVER MARRIED | 8. DATE OF BIRTH | | 9. AGE (In years | IF UNDER 1 YEAR | IF UNDER | 24 HRS. |
| MALE | NEGRO | WIDOWED | DIVORCED [| SEPT. 25 | 1887 | lost birthdoy) 80 yrs. | Months Doys | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER 10b. KIND OF BUSINESS OR INDUSTRY FARMING | | | | 11. BIRTHPLACE (Con | | or foreign country) | 12. CITIZEN C | ? | |
| 13. FATHER'S NAME | | FA | MITING | MARYLA | | | U.S. | A. | |
| TO. TATTLER'S HAME | HERIDA DA | MIDO | | 14. MOTTER'S MAID | | | | | |
| IS WAS DESEASED I | | RNES | OCIAL SECURITY NO. | 17 INFORMANT | DELL | TARREST AND LABOUR. | | | |
| (Yes, no, or unknown | VER IN U.S. ARMED FORCES? (If yes give war or dates or | of service) | SOCIAL SECURITY NO. | 17. INFORMANT | | Addres | | | |
| NO | | | 8-38-8600 | MRS. RUTH | PORTE | e Lexingt | ON PARK | | |
| 18. CAUSE OF | DEATH (Enter only one cou EATH WAS CAUSED BY: | se per line for | (a), (b), and (c).) | 11 | | | | TERVAL BET | |
| TAKI I. U | IMMEDIATE CAUSE | (a) (O) | nehral | Homors | oug. | 2 | 1 | | SKAN |
| 3311 | DUE | TO | , , | ne Vascue | , , | , , | | | |
| Conditions, if o | | (b) H | ybelener | ne Vascul | and | Disaro | | | |
| rise to immedi | | | | | | | | | |
| last. | deriving coose | (c) | | | | | | | |
| PART II. OTHER | SIGNIFICANT CONDITIONS C | | O DEATH BUT NOT RELATE | D TO THE TERMINAL DISEASE | CONDITION | GIVEN IN PART 1(0) | 19 | PERFORM | ED? |
| \$ | | | | | | | | YES | NO A |
| OR CONTRIBUTION (IF EITHER, NOT) | VAS UNDERLYING ☐ NG ☐ CAUSE OF DEATH FY MEDICAL EXAMINER) | 20b. DES | SCRIBE HOW INJURY OCCU | RRED. (Enter noture of injury | in Port 1 o | r Port II of item 18.) | | | |
| Hour Hour | NJURY Month, Day, Year a.m. p.m. 19 | 20d. IN While at work | Not While | e. PLACE OF INJURY (Home, factory, street, office bldg., | | 20f. (City or town) | (County) | (| State) |
| | tify that (I) (this has deceased alive an_ | pital) attend | ded the deceased fro | m OCF 28 I that death accurred | , 19 <u>6</u> | | 19 <u>6</u> /t | | |
| 22o. SIGNATUI | | alix | no la | M.D. ATTENDING PHYS. | MED. DIRECT | OR STAFF PHYS. | 22b. DATE SIG | NED -9 6 | 7 |
| 22c. PHYSICIAL NAME (Ty | | PATRICK | MD | 22d. ADDRESS | TOMON | DADIC MADY | 4.3770 | | |
| | No Me 1 | | | | | PARK MARYL | | | |
| 23a. BURIAL, CREMA | | | HOLY FAC | | | EREAT MILLS | on) (Count | ,, | Md. |
| 24. FLINERAL DIREC | m. Welas | 1/ | ADDRESS | 2Sa. F | EC'D BY RE | GISTRAR 25b. REC | GISTRAR'S SIGNATU | | |
| | | | | | | 1967 20 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death filled in **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completel filled in director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper should be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 72 Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 20 M 1/66

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PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital ar attending physician. director, page should be filed FUNERAL 9 VR A15 (4) 25M 1/67

haurs after death

(we) last JAMES P M. D. JARBOE GREAT MILLS. MARYLAND 23o. BURIAL, CREMATION 23b. DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Bur REMOVAL (Specify) MORGANZA ST. MARY 8 MD.
AR 25b. REGISTRAR'S SIGNATURE ST. JOSEPHS CHURCH CEMETERY 2Sa. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 1967 Ochonlas W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

Joseph , Joseph SHALLYRAN (BLUE, MARYLAND)

War. 11-24-07 Br. Comment Change Courtery Mondalls, 81, Comments, 81, Co

WEST TELL

W. CLARKS MATTINGLEY LEGINARDTOWN, MAR LAND

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MARYLAND STATE DEPARTMENT OF HEALTH

| | | | | Division of STATIS | TICAL RESEA | ARCH AND RECO | RDS, 30 | I W. PRESION SIR | EEI, BALTII | MORE, MARYL | AND 21201 | |
|--|------|---------------|-------------------------------|---|-----------------|----------------------|-----------|--------------------------------|-------------------|------------------------|-------------------|------------------------------------|
| (M) | | | 1443 | 3 | | CERTI | FICATE | OF DEATH | | ys alle | 1443 | 8 |
| e d d | | | PLACE OF DEATH | | | TENER DE N | | 2. USUAL RESIDENCE | (Where deceose | d lived, if instituti | on: Residence bet | ore odmission) |
| r de | | | ST. MA | ARY,S | M() | RYLAND MA | CIAND | o. STATE MARYLAND | | ST. MAI | RY.S | |
| s after the frages rs afte | | | | f outside corporate limit | | c. LENGTH OF STAY | | c. CITY OR TOWN (If o | utside cornorat | e limits write RUR | Al and give near | est town) |
| rs o | | | write RURAL and | give nearest town) | *, | | | | | | are one give need | 4.2 |
| 2 6 | | | LEONARDTO | | A 2- 1 - 2-1 | | | | TON PAI | K Md. | | e. IS RESIDENCE |
| 4 (in \$22) | 1 | - 1 | | AL OR INSTITUTION (If no | | give street oddress) | | d. STREET ADDRESS | | | THEFT | ON A FARM? |
| in 24 ho med in popers. | 16 | | ST. MAI | RY,S MOSPIT | AL | | | LEXINGT | ON PARI | | | YES NO |
| vithi ogn witi | | | NAME OF DECEASED | | rst | Middle | 1-1-1 | Lost | 4. DATE | Mont | h D | oy Year |
| e executed with and completely remove carban n ony event, with | | | Type or print) | MA | RY | ETHEL | | BRISCOE | OF DEATH | OCTOBI | ER 27 | 19 67 |
| ompleto ve carl event, | | S. | SEX | 6. COLOR OR RACE | 7. MARRIED | NEVER MARRI | ED A | 8. DATE OF BIRTH | 9. | AGE (In years | IF UNDER 1 YEAR | |
| col col col | | 1 | PEMALE | NEGRO | WIDOWED | DIVORC | ED 🗍 | 1/14/1917 | 100 | lost birthdoy) 50 yrs. | Months Doys | Hours Mir |
| ond ren | 100 | 10o | USUAL OCCUPATION | (Give kind of work done | 10b. KI | ND OF BUSINESS OR | | 11. BIRTHPLACE (Count | y & Stote, or for | | 12. CITIZEN | OF WHAT |
| cion cose eose and in | | duti | TOUSEKEET | life, even if retired) | DON | DUSTRY | | ST. MARY | | | U.S. | 1? |
| ertificate be executed with physicion ond completely en pleose remove carbor aval, and in ony event, wi | | - | FATHER'S NAME | Jan 16 | 1001 | THOTTO | | 14. MOTHER'S MAIDEN | | LIMAND | 0.0. | 25.0 |
| shy shy | | 10. | | TOU DETC | don. | | | | | | | |
| The The | | 15 | RANDO | R IN U.S. ARMED FORCES? | | SOCIAL SECURITY NO. | 17 1 | DORA INFORMANT | REED | A J.J., | | |
| ne death certific ottending phys permit. Then p ion, or remayal, | M. | (Ye | s no or nuknowu) | (If yes give war or dotes o | of service) | | | | | RT. 2,Addr1 | | |
| ottendii permit. ion, or re | 100 | | NO | | 34 | 3-20-6523 | BA | RBARA E. B. | ANKINS | HOLLYWO | OOD Md. | |
| | | | 18. CAUSE OF DE | ATH (Enter only one course WAS CAUSED BY: | se per line for | (a), (b), ond (c).) | | 1 10. | | 0 | | NTERVAL BETWEEN ONSET AND DEATH |
| y thy | 1.3 | | PART I. DEAT | IMMEDIATE CAUSE | (0) | arcil | 2011 | ray pa | nch | A.S | | DISET AND DEATH |
| quires that the physician. signed by the burial-transit burial, cremat | | | 13 1 X | DUE | 10 | 11-+1 | | 011 1 | ~ ~ . | | | |
| quires physic signed buriol- burial, | 0.0 | | Conditions, if ony, | | (b) | with | N | wane | NZ) | | | |
| req g pl | | | rise to immediat | | 10 | | | | | | THEFT | |
| e low retending as been os the prior to | | | last. |) | (c) | | | | 1 | | | |
| The low r or ottending e has been use os the olth prior to | | - | PART II. OTHER SI | GNIFICANT CONDITIONS C | ONTRIBUTING 1 | O DEATH BUT NOT R | ELATED TO | THE TERMINAL DISEASE CO | ONDITION GIVE | I IN PART 1(o) | 1 | 9. WAS AUTOPSY PERFORMED? |
| T of a see | 1 | CERTIFICATION | | CANEL | | | | | | | | YES NO |
| rsician: ospital or certificate hed for un | | IFIC | 20g. ACCIDENT WAS | S UNDERLYING | 20b. DE | SCRIBE HOW INJURY | OCCURRED. | (Enter noture of injury in | Port I or Port | II of item 18.) | - | |
| E E E E | 1110 | CERT | OR CONTRIBUTING | CAUSE OF DEATH MEDICAL EXAMINER) | | | | | | | | |
| ATTENDING PHYSICIAN: The stained by the hospital or otte CTOR: After this certificate has should be detached for use o ith the State Dept. of Health pr | | | | JRY Month, Day, Year | 20d It | NJURY OCCURRED | 20e PLA | CE OF INJURY (Home, for | m. 20f. | (City or town) | (County) | (Stote) |
| this Do Do | | MEDICAL | Hour o.r | n. 10 | While | Not While | | ory, street, office bldg., etc | | 0.7 | 27/7 | (0.000) |
| by the fifter pe control of the cont | | | p.r | | at worl | | | Vit De | 1007 | ou. | 2/6/ | .1 . (1) () |
| A P | | | | fy that (I) (this has | pital) atten | ded the decease | tram_ | 7 | | fram causes | , 19, | that (I) (we) |
| ATTENI etained CTOR: / should ith the | | | | eceased alive an_ | 1010 | 27 1967 | ana ma | t death accurred a | N EX O SW | rram causes | 22b. DATE SI | |
| | | | 220. SIGNATURE | 1011 | 111 | 0 | | ATTENDING | MED. | STAFF | | |
| be ded | | - | an Duvisionalis | + (CA | 2 10 | ~ | M.I | D. PHYS. 22d. ADDRESS | DIRECTOR | PHYS. | 1 10 - | 30 - 67 |
| moy be RAL DIR | 1 | | 22c. PHYSICIAN'S NAME Type | TOPO | A B// T | | | | ALL TRUMP | DIV MD | | |
| TO HOSPITAL OR Poge 4 moy be r TO FUNERAL DIRE director, poge 3 should be filed w | 30 | | | J. C. RU | | | | | | RK, MD. | 1 12 | |
| He ge | | 230 | BURIAL, CREMATIC | | | 23c. NAME OF CE | | | | ATION (City or Tov | | ., |
| 5 5 5 A | | 0 | BURTAL Specify | | /1967 | ST. PET | ERS C | LAVERS | F | IDGE | ST. MA | RY S Md. |
| 0 | | 74 | JUNERAL DIRECTO | RWolds | - | ADDRESS | | 2So. REC | D BY REGISTR | R 2Sb PF | GISTRAR'S SIGNAL | JKE AAR |

LEONARDTOWN

MARYLAND

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14440 CERTIFICATE OF DEATH 14435 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY b. COUNTYST - MARY 8 o. STATE ST. MARY 18 MARYLAND MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) DOA AVENUE RURAL d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ST. MARY S HOSPITAL YES NO NAME OF First Middle Last 4 DATE Month Dov Year DECEASED OF DEATH MAUDE 67 MARY CHESELDINE OCTOBER 17. (Type or print) S. SEX IF UNDER 1 YEAR 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 24 HRS. birthdoy) Months Hours MARCH 13.1891 FEMALE WHITE WIDOWED DIVORCED 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if refired) INDUSTRY COUNTRY? MARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME FRANCIS OWENS GENEVIEVE COOKE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) CARL C. CHESELDINE AVENUE, MARYLAND 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS PERFORMED? YES NO 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) ot work ot work 21. I certify that (1) (this haspital) attended the deceased fram. 19 19___, that (I) (we) last . ta M, fram causes and an the date stated above. 19 ____, and that death accurred at_ saw the deceased alive an 22b. DATE SIGNED 226. SIGNATURE M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S

FUNERAL DIRECTOR: After this certificate directar, page 3 shauld shauld be filed with the VR A15 (4) 25M 1/67

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PHYSICIAN: The

ATTENDING

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24 haurs after death

requires that the death certificate be executed within

24. FUNERAL DIRECTOR

NAME (Type)

23o. BURIAL, CREMATION,

BEMOVAL (Specify)

23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Ост. 20.1967 ALL SAINTS CEMETERY ADDRESS

2So. REC'D BY REGISTRAR

(County) (Stote) OAKLEY, ST. MARYLAND

W.CLARKE MATTINGLEY LEONARDTOWN, MARYLAND

JOHN F. FENWICK M.D.

LEGNARDTOWN, MARYLAND

23d. LOCATION (City or Town)

AKLEY, S. ANYING ANTINE

Taken's mail

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MARYLAND STATE DEPARTMENT OF HEALTH

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District ... st. dary's - 21775. fastgach atyman .24 Frederick Skigher With heater while cober 1 Majo white white PARKED TO BREED WITH THE BEST OF THE BEST modificance. Uniquester - - Priscilla Look VEST SHIP STORY RESERVE DESCRIPTION HE THE STREET STREET, ASSESSED IN CONTRACTOR OF THE STREET, STREE The state of the s RETERMY GUYTHER WEEKINGGAYLES, MICH BURGAS WEST-LOR STATIONS SEMI PRINTER MEDI (The Hunt Friedrich Harbert Sin Court of the

14437

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14442

| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) | | | | | | | |
|-------------------------------|-----------------------------------|-----------------------|-----------------------------|---|-------------|---------------------------------|------------------|-------------------|---------|--|--|
| St. Mary | 7 1 S | | MARYLAND | o. STATE Maryland St. Mary's | | | | | | | |
| b. CITY OR TOWN | (If outside corporate lim | its, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If o | utside corp | porote limits, write RU | RAL and give neo | rest town) | | | |
| St. Mary | nd give nearest town) 7 S Hospita | 1 | + HOUR | St. Ini | 2065 | | | 18 | 1 | | |
| | TTAL OR INSTITUTION (IF | | | d. STREET ADDRESS | 8000 | | | e IS RESI | | | |
| Leonardt | own, Maryla | and | | | | | | YES _ | NO NO | | |
| 3. NAME OF DECEASED | | First | Middle | Lost | 4. DAT | TE Mon | th D | | ear | | |
| (Type or print) | | 7 | A | CHISLEY | DEA | | | | 67 | | |
| S. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED WIDOWED | NEVER MARRIED DIVORCED | | 22 | 9. AGE (In years lost birthdoy) | Months Doy | | Min. | | |
| | ON (Give kind of work don | | CIND OF BUSINESS OR | 11. BIRTHPLACE (Stote | | n country) | 12. CITIZEN | OF WHAT | | | |
| during most of working | g life, even if retired) | | NDUSTRY | - 07-07-07 | J | | COUNTR | y ? | | | |
| LABORED | | | | ST. INIGO | EB MA | RYLAND | U.S.A | 1 | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN | NAME | | | | | | |
| HAR | RY CHISLEY | | | ALL | CE CA | RTER | | D. 11 | 5 1 | | |
| | VER IN U.S. ARMED FORCES | | SOCIAL SECURITY NO. 17. | INFORMANT | | Addr | ess | | | | |
| (Yes, no, or unknown | (If yes give wor or dotes | | 20-16-5054 Est | | | 0- 1 | | | | | |
| Tio cause of | DEATH (Enter only one co | | | ELLE G. UNI | BLEI | DITTIEU | | NTERVAL BE | TWEEN | | |
| | ATH WAS CAUSED BY: | pose bei ille io | | 44 14 | | 1. 1 | | ONSET AND | | | |
| | IMMEDIATE CAUS | E (o) | Arteriosclero | cic cardiov | ascul | lar diseas | e | | | | |
| 422 | | E TO | | | | | 1 | | | | |
| Conditions, if on | | (b) | | | | | | | | | |
| stoting the und | | E TO | | | | | | | | | |
| last. |) | (c) | | | | | | | | | |
| PART II. OTHER | SIGNIFICANT CONDITIONS | CONTRIBUTING | TO DEATH BUT NOT RELATED TO | THE TERMINAL DISEASE CO | ONDITION (| GIVEN IN PART 1(o) | | 9. WAS AUT | | | |
| 200. EXTERNAL (PRIMARY Dor C | | HI MA | Pulmonary tub | | | | | PERFORM YES TO | | | |
| 20o. EXTERNAL | CAUSE WAS | 20b. D | ESCRIBE HOW INJURY OCCURRED | . (Enter noture of injury in | Port L or | Port II of item 18.) | | 43005 | - | | |
| PRIMARY Or C | ONTRIBUTING | 200.0 | | (| | | | | | | |
| | | 201 | INJURY OCCURRED 20e. PL | ACE OF INJURY (Home, for | m. 20 | Of. (City or town) | (County) | | (Stote) | | |
| 20c. TIME OF IN | JURY Month, Doy, Yeor o.m. | While | | ctory, street, office bldg., etc | | i. (city of town) | (county) | | (21016) | | |
| 2 | o.m. 19 | | rk Ot work | | | | | | | | |
| 21. I certi | ify that I took chor | ge of the re | mains described above, h | eld on Autapsy | Inspe | ection XX, Inq | uiry 🔲, a | nd in my | opinio | | |
| death resu | Ited fram: Natu | ral causes [| X Accident Su | icide . Hamicid | еП | Undetermined n | ngnner 🗍 | | | | |
| | | | | CHIEF MEDICA | | | | | | | |
| ACTUAL | 110Penl | h | 751 | M.D. ASSISTANT ME | | | | 22. DATE | SIGNED | | |
| SIGNATURE | LU-CI / CT | | 1100 | DEPUTY MEDIC | | 44 | | | | | |
| EXAMINER'S NAME (Type) | WERNER U. | SPTTZ | M > | | | wn, or county) | | 10-16 | -67 | | |
| 23o. 8URIAL, CREMAT | | | 22. NAME OF CEMETERY OF | | | LOCATION (City or To | own) (Cour | nty) (| (State) | | |
| REMOVAL (Speci | fv) | | | | | | | ,, | | | |
| BURIAL | | 19, 1967 | ADDRESS | AVERS CEMET | D 87 REG | RIDGE ST | MARY B | MARY | LANG | | |
| 24. FUNERAL DIRECT | | AL TOP | | | | 10.7 | | | | | |
| W.BLARKE | MATTINGLEY | LEONAR | DTOWN. MARYLAN | DAT | T 18 | 8 1967 0 | Clearlan | Vacdas | 2 | | |

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| | | MARYLAND STA DIVISION OF STATISTICAL RESEARCH AND R | FCORDS | PARTMENT OF | F HEALT | H T BALTIMOL | DE 1 MADY | AND |
|---|---------------|---|------------|--|---------------------|--------------------------------|--------------------------------|-----------------|
| | | | | E OF DEATI | | I, BALTIMO | 144 | 44 |
| | 1. | LACE OF DEATH . COUNTY St. Mary's MA | | 2. USUAL RESIDEN a. STATE | | b. COUN | TY | |
| | | CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | TAY IN 1b | c. CITY OR TOWN (I | aryland outside cor | | St. Mar te RURAL and gl | ve nearest town |
| | | Leonardtown | | Lexington | n Park | | | 18-1 |
| 6 | | I. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give stree St. Mary's Hospital | t address) | d. STREET AOORESS | | 104 | | ON A FARM? |
| | 3. | IAME DF First Middle ECEASED | | Last | 4. DATE | Month | Oay | |
| | - | Type or print) Flizaboth (N | Vone) | Demko | DEATH | | | 0 19 67 |
| | 5, | 7. MARKIEU NEVER MARK | | 8. OATE OF BIRTH | 9. | AGE (In years last hirthday) | FUNOER 1 YEAR Months Oays | Hours Min. |
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| | 13. | IQUSEWIFE DOMESTIC | | CZECKOSC | | | U.S. | A. |
| | | | | | | | | |
| | 15 | John Koval VAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY | NO. 17. | INFORMANT |) WIN | Address | | |
| | (Ye | no, or unkown) (If yes give war or dates of service) N/A | | RS. GRACE NO | RWOOD | | newood A | ve. |
| - | | 8. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and | d (c) 1 | 71 | | 11 | INTE | RVAL BETWEEN |
| | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aur, Cular | +ib1 | rillation | 1 W | ith | Olic | CI AILD DEATH |
| | | 443 X OUE TO Punhalica | - 1 | 11. | 1.1 | /. | 1. | |
| | | conditions, If any, which are rise to immediate (b) | VI . F | TYPETTENSI | reart | erioscler | 0110 | |
| | | ause (a), stating the OUE TO Cardio VASINIA | rdice | ense Cana | VITIVE | heart & | riture | |
| | S | ART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU | ITNOTRELA | TEO TO THE TERMINAL | DISFASE CON | DITIONGIVENINE | ART 1(a) 119. | WAS AUTOPSY |
| | CAT | | | | | | YE | PERFORMEO? |
| 1 | CERTIFICATION | 0a. ACCIOENT WAS UNDERLYING [] 20b. DESCRIBE HOW IN | JURY OCCU | IRREO. (Enter nature o | f Injury In Pa | rt I or Part II of | | THO LA |
| 1 | | R CONTRIBUTING ☐ CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | ulita) = | |
| | MEDICAL | Oc. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED Hour a.m. While Not While | | CE OF INJURY (Home, f ry, street, office bldg., e | arm, 20f. (| City or town) | (County) | (State) |
| | MED | p.m. 19 While Not While at work | | . y, ou out, onled bidg., t | | | | |
| | | 21. I certify that (I) (this hospital) attended the deceased | | | 9 61 , to_ | Oct 30 | 2, 1962, th | at (I) (we) las |
| | | saw the deceased alive on 30 19 67 | | death occurred at 2 | 50 AM, fro | m the causes a | nd on the dat | e stated above |
| | | 22a. SIGNATURE | | ATTENOING - | MEO. | STAFF | 22b. DATE SI | NEO |
| | | 2c. PHYSYCIAN'S | M.D | . PHYS. | OIRECTOR [| PHYS. | 10 - 30 | - 67 |
| | | 2c. PHYSCIAN'S NAME (Type) J. C. ROA, M. D. | | | GTON PA | RK, MD. | | |
| | 23a | BURIAL, CREMATION, 23b. OATE THEREOF 23c. NAME OF | CEMETERY | OR CREMATORY | 23d. LO | CATION (City, to | vn or county) | (State) |
| | 1 | BYRIAL (Specify) 11 - 2 - 67 ST. JAN | MES CE | DWEIVERY | | INGTON PA | | |
| | 24. | FUNERAL DIRECTOR Molely AOORESS | | | C'O BY REGIS | | Clarks SIGN | ATURE |
| | 1 | OHN M. WELCH LEONARDTOWN, M | ID. | OATEN | JV 2 | 1967 90 | maries | - Jan |
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14445 14439 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY a. STATE ST. MARY MARYLAND CHARLES requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside corparate limits, write RURAL and give negrest tawn) 11 DAYS PORT TOBACCO LEGNARDTOWN RURAL d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS carbon po ST. MARY'S HOSPITAL YES NO X NAME OF Last 4. DATE Month Doy Year Lucille DECEASED DEPEW MARY 67 (Type or pnnt) DEATH OCTOBER IF UNDER TYEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years remave last birthday Manths Days Hours WIDOWED and in any DIVORCED MAY 5. 1914 FEMALE WHITE 1Da. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (Caunty & State, or fareign cauntry) during mast af working life, even if retired) please COUNTRY? INDUSTRY attending physician termit. Then please Housework MARYLAND U.S.A Domestic 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, Daniel Rice Maude Wenk 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, reconstruction) (If yes give war ar dates af service 212-34-8700 CLARENCE DEPEW . Port Tobacco . Md. 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c).)
PART I. DEATH WAS CAUSED BY: burial-transit IMMEDIATE CAUSE (o) signed by Page 4 may be retained by the haspital ar attending physician. DUF TO Conditions, if any, which gove rise ta immediate cause (a), DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar ta has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X 2Dg. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II af item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Doy, Year Hour 'a.m. factory, street, affice bldg., etc.) Not While 21. I certify that (I) (this haspital) attended the deceased fram director, page o such the saw the deceased alive an_ and that death occurred at M. fram causes and an the date stated above DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING 10-5-67 DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN J. Roy Guyther MECHANICSVILLE, MARYLAND 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (State) REMOVAL (Specify) 10-9-67 St Ignatius Hilltop, Charles, Md. 0 Burial 2Sb. REGISTRAR'S SIGNATURE 25o. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 The Huntt Funeral Home, Waldorf, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| | 1444 | O | CERTIFIC | ALE OF DEATH | | 14446 |
|---------------|-----------------------------|--|------------------------------------|---|---------------------------------------|-------------------------------------|
| 11 | PLACE OF DEATH | | | | Where deceosed lived, if institution: | Residence before odmission) |
| 3/ | o. COUNTY | Y.S | MARYLAND MARYLAN | o. STATE MARYT.AND | b. COUNTY BALTTI | MOBE |
| | b. CITY OR TOWN | If outside corporate limits, | c. LENGTH OF STAY IN 11 | c. CITY OR TOWN (If ou | tside corporote limits, write RURAL | |
| 90 3. 5. | LEONARD | d give nearest tawn) | 2 Mo. | BALTINO | RE Md. | 03-2 |
| 0 | | | n hospitol, give street address) | d. STREET ADDRESS | ALD PRO | e. IS RESIDENCE ON A FARM? |
| 90 | ST. MAR | S NURSING B | OMR | 2405 BTRCH | Dr. BALTI, Md | YES NO NO |
| 3. | NAME OF | First | Middle | Lost | 4. DATE Month | Doy Year |
| | (Type or print) | MATIL | DA MA | DUNKINS | OF DEATH OCTOBER | 18 19 67 |
| S. | SEX | 6. COLOR OR RACE 7 | MARRIED NEVER MARRIEO | 8. DATE OF BIRTH | 9. AGE (In years IF | UNDER 1 YEAR IF UNDER 24 HRS. |
| | FEMALE | CAUCASIAN | WIDOWEO DIVORCED [| 2/19/1884 | lost birthdoy) M | onths Doys Hours Min. |
| 10 | O. USUAL OCCUPATIO | Give kind of work done | 10b. KIND OF BUSINESS OR | | & Stote, or foreign country) | 12. CITIZEN OF WHAT |
| ar | ring most of working | ire, even it retired) | DOMESTIC | BALTIMOR | E MARYLAND | COUNTRY? |
| 13 | 3. FATHER'S NAME | | | 14. MOTHER'S MAIDEN N | NAME | |
| | GEOR | GE W. MARS | WALL. | LAVANIA | PRESTON | |
| 19 | S. WAS DECEASED EV | R IN U.S. ARMED FORCES? (If yes give wor or dotes of se | 16. SOCIAL SECURITY NO. | 17. INFORMANT | Address | |
| (, | res, no, or unknown) | (II yes give wor or dores or se | 213-10-6332-1 | GEORGE D | UNKES SAN | EAS#2 |
| | 18. CAUSE OF D | EATH (Enter only one couse | per line for (a), (b), and (c).) | | | INTERVAL BETWEEN |
| | PART I. DEA | IMMEDIATE CAUSE (o) | Electrolyte, | Im Balance | 2 | ONSET AND OEATH |
| | 14221 | DUE TO | P | , n.1 | 1. | 41 |
| | Conditions, if ony | | Meaningra | a + coll | 11 2 | 29 km " |
| | stoting the unde | | Der | TP - 111 | 0.33 | |
| | lost. |) (c) | De gentrexine | | ewer Justane | _ |
| 1 × | PART II. OTHER S | GNIFICANT CONDITIONS CONT | TRIBUTING TO DEATH BUT NOT RELATED | O TO THE TERMINAL DISEASE CON | IDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? |
| 7 3 | | | | | | YES NO |
| CERTIFICATION | 20o. ACCIDENT WA | S UNDERLYING CAUSE OF DEATH | 205. DESCRIBE HOW INJURY OCCUP | RRED. (Enter noture of injury in I | Port I or Port II of item 18.) | |
| | | MEDICAL EXAMINER) | | | | |
| MEDICAL | 20c. TIME OF INJ Hour o. | JRY Month, Day, Yeor n. | 20d. INJURY OCCURRED 200 | e. PLACE OF INJURY (Home, form foctory, street, office bldg., etc.) | | (County) (Stote) |
| 2 | p. | | ot work L ot work L | 0-1-0-3 | 157 (4/16 | |
| | 21. I cert | fy that (I) (this hospit | al) attended the deceased fra | m_8/23_,1 | 96/ to 10/18 | _, 19 <u>62</u> , that (I) (.we) la |
| | 220. SIGNATURE | eceased alive an | 199(7,)0110 | i mai deam accurred of | | 22b. DATE SIGNEO |
| | 220. SIGNATURE | 201. | 242444 | M.D. ATTENOING X | MED. STAFF DIRECTOR PHYS. | 10/10/19 |
| | 22c. PHYSICIAN'S | 2000 4 14 | 2000000 | 22d. ADDRESS | OIRECTOR CO PRIS. CO. | 19/9/6/ |
| 1 | NAME (Type | | NWICK M. D. | LEONARI | DTOWN MARYLAND | |
| 23 | Bo. BURIAL, CREMATI | ON. 23b. DATE THERE | | | 23d. LOCATION (City or Town) | (County) (State) |
| | Burial (Specify | 10/21/ | | l Memorial | | |
| 1 3 | A FUNERAL DIRECTO | P | ADDRESS | 2So REC'E | Baltimore Baltimore 256. REGIST | RAR'S SIGNATURE |
| 7 | J.T.Sta | nsbury 641 | l Windsor Mill | Rd. DATE A | A B A B | |

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O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death

Poge 4 moy be retained by the hospitol or attending physician.

VR A15 (4) 25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and compiletely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove cobon popers. Pages should be filed with the State Dept. of Health prior to burial, cremotion, or removal, and in ony event, within 72 hours all

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14447

| | E OF DEATH DUNTY | Mary Is | | MARYLAN | A CTATE | E (Where deceosed liv | ed, if institution b. (OUNT) | | |
|-----------------------------|---|---|-----------------------------|-----------------------------|---|----------------------------|---------------------------------|-------------------------|-----------------------------------|
| b. (11 w | TY OR TOWN (If rite RURAL and c | outside corporote limits, ive nearest town) | | c. LENGTH OF STAY IN 1 | | f outside corporate lim | its, write RURA | L ond give neorest | town) |
| d. NA | | OR INSTITUTION (If not in | | | d. STREET ADDRESS | RURAL | | | ON A FARM? YES NO |
| 3. NAM DECE (Type | ASED or print) | First | | Middle LEARY | ELLIS | 4. DATE OF DEATH | Month OCTOBE | Doy 9. | Year 19 67 |
| S. SEX | | S. COLOR OR RACE 7 | MARRIED WIDOWED | NEVER MARRIED [DIVORCED [| 8. DATE OF BIRTH JAN. 19, 18 | - Inst | | Months Doys | Hours Min. |
| 10o. USU during m | AL OCCUPATION (post of working life | Give kind of work done e, even if retired) | | ND OF BUSINESS OR DUSTRY | 11. BIRTHPLACE (COU | nty & Stote, or foreign of | ountry) | 12. CITIZEN OF COUNTRY? | WHAT |
| 13. FATI | HER'S NAME | ELIUS LEARY | | | 14. MOTHER'S MAID | EN NAME | JEY | | |
| | | N U.S. ARMED FORCES? 'yes give wor or dotes of s | | OCIAL SECURITY NO. | 17. INFORMANT R.CARROLL EL | | Address | MARYLAND | |
| rise stat last | _ | ing couse (c), (c) | Ceur | eccilar 7 | ihillation tec heart D TO THE TERMINAL DISEASE | Conver Disease | led PARI 1(0) | 10 | y your |
| CERTIFICATION 300 005 | . ACCIDENT WAS U CONTRIBUTING C EITHER, NOTIFY MI | NDERLYING I CAUSE OF DEATH | | | RRED. (Enter noture of injury | | | | PERFORMED? |
| 7 | | Month, Doy, Year | 20d. IN While ot wark | - Not While - | le. PLACE OF INJURY (Hame, foctory, street, office bldg., | | y or town) | (County) | (Stote) |
| | saw the dec | that (I) (this hospit | | ed the deceased fra | im d that death accurred | , 19, ta atM, fra | m causes ar | | at (I) (we) las e stated abave |
| 1 | c. PHYSICIAN'S NAME (Type) | JOHN F. FEI | em | mick. | M.D. ATTENDING PHYS. 22d. ADDRESS | | STAFF PHYS. | 10.10 | . 4-0 |
| | | O 1 8 1 61 | THICK | 1110 00 | RY OR CREMATORY | LEVITARI | T O HIT | n) (County) | |

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W. GLARKE VATTIBLES LEONARDYONN, WARYLAND COTTO

MARYLAND STATE DEPARTMENT OF HEALTH

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October 25, 134

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June 17, 1948 117

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AE THE PROPERTY

MARYLAND STATE DEPARTS Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR FOR STATE! MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whara deceased livad, If institution; Residence before admission) b. COUNTY NEWPORT NEWS necessary, ector. Page a. COUNTY VTRGINIA ST MARY'S MARYLAND b. CITY OR TOWN (if outside corporate limits, director. C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT EUSTIS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? POTOMAC RIVER 1106-B THOMPSON CIR. YES NOX NAME OF First Middle 4. DATE Year within 24 hours after death. If an 18, Give Pages 1, 2, and 3 to the form PM3. Page 5 may by DECERSED WILLIAM JAY FRANCIS OCTOBER 10 67 (Typa or print) DEATH 19 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX last birthday) Months MALE CAU 25 WIDOWED [DIVORCED угв. ge 5 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (Stata or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) U.S. ARMY NEWPORT NEWS, VIRGINIA ARMY AVAITOR USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME MORGAN B. FRANCIS VIOLET JONES 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Addrass Item 18. Yes, no, or unkown) (Ifyasgivawarordatasofservica)
Yes 15 JAN 57-Pres. with U.S.ARMY RECORDS 18. CAUSE OF DEATH [Entar only one cause par line for (a), (b), and (c).] INTERVAL BETWEEN Office along burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Severe open crushing head injury with brain TNSTANT laceration and contusion assoicated with should be 0 laceration and rupture of heart associated with word "pending" i dical Examiner's O uld be used as a bu aircraft accident gava rise to immadiata causa (a), stating the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II ALL CERTIFICATION PERFORMED? Multiple fractures of extremities; crushing chest injuries NO EXAMINER: This 2Da. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Entar natura of injury in Pert I or Part II of itam 18.) writing the vector of the control of PRIMARY OF CONTRIBUTING CAUSE OF DEATH. Forces of sudden decelleration when aircraft crashed certificate, writing certificate, writing warded to the Chief. DIRECTOR: Page 3 20c. TIME OF INJURY 20d, INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Month, Dey, Yaar (County) (State) factory, street, office bldg., etc.) at work at work Airplane Potomac River St Mary's Md. Oct 10 19 67 21. I certify that I took charge of the remains described above, held an Autopsy 🛣 . Inspection X. Inquiry and in my opinion death resulted from: Natural causes Accident X. Suicide Homicide , Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED should be in FUNERAL SIGNATURE or its DEPUTY MEDICAL EXAMINER OCT 13, 1967 EXAMINER'S WILLIAM D. BOYD, MD NAME (Typa) Addrass (Straat, city, town, or county) please 4 shoul O FUN Health 22e. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (State) REMOVAL (Specify) Virginia Arlington National Oct 18,1967 Burial 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR Ellicott City, Md Howard County Funeral Home of Harry Witzke

VR A15ME 5M 1/62

ORIGINALLY REPORTED ON REGULAR DEATH CERTIFICATE AND SHOULD HAVE BEEN M.E.

FILM G394 - 11/15/67 mnb

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WAS AUTOPSY

PERFORMED? YES X

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22. DATE SIGNED

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Virginia

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INSTANT

16446 FOR STATE HEALTH DEPT PLACE OF DEATH delay is and 3 to Page o. COUNTY St Mary's b. CITY OR TOWN (If outside corporate limits, , 2, L. P.M3. P NEAR PINEY POINT d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e, writing the ward "pending" in pencil in Item 18. Give Pages 1, farwarded ta the Chief Medical Examiner's Office along with farm POTOMAC RIVER 00 Give Pages 24 haurs after death. NAME OF DECEASED OCTOBER ROGER FULTZ CLINTON (Type or print) AGE (In years IF UNDER 8. DATE OF BIRTH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost bighdoy) Months in Item 18. 19 AUG 39 MALE CAU DIVORCED WIDOWED and 2 12. CITIZEN OF WHAT 11. BIRTHPLACE (Stote or foreign country) 10b. KIND OF BUSINESS OR 10o. USUAL OCCUPATION (Give kind of work done it. File pages lar 72 hours after o during most of working life, even if retired)
FLIGHT ENGINEER . ARMY NASHVILLE. TENN 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME in pencil executed within UNKNOWN SAM C. FULTZ permit. File 17. INFORMANT Address 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dotes of service)
YES 4 Jun62-Pres within / 409583585 U.S.ARMY RECORDS 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit Severe open crushing head injury with brain event \ PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) lacertation and rupture of heart and contusion writing the ward certificate shauld DUE TO associated with the brain laceration associated any Conditions, if ony, which gove (b) rise to immediate couse (a). with aircraft accident. DUF TO stoting the underlying couse pup SD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) used Multiple fractures of extremities, crushing chest injuries the certificate, pe 4 shauld be 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20g. EXTERNAL CAUSE WAS 3 shauld PRIMARY Or CONTRIBUTING Б Forces of suddent decelleration when aircraft crashed MEDICAL EXAMINER: CALISE OF DEATH. crematian, 20e. PLACE OF INJURY (Home, form, (City or town) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year While of work of work foctory, street, office bldg., etc.) 10:45 Hour o.m. DIRECTOR: Page Potomac River StMarv's Md Aircraft Oct 10967 please execute Inspection X, Inquiry X, 21. I certify that I taok charge of the remains described above, held an Autopsy 🛣 Accident X Hamicide . Undetermined manner funeral directar. Suicide death resulted from: Natural causes CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER priar SIGNATURE FUNERAL I DEPUTY MEDICAL EXAMINER **EXAMINER'S** WILLIAM D. BOYD, MD Address (Street, city, town, or county) Health NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 50 REMOVAL (Specify) Oct 18,1967 Arlington National Burial 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL Minules Jungan

Ellicott City, Md

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MARYLAND STATE DEPARTMENT OF HEALTH

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Office olong with form

word "pending" in pencil in Item 18. Give Pages the Chief Medical Examiner's Office along with form

icate, writing the word be forwarded to the Ch

please execute the certificate,

funeral director.

EXAMINER: This certificate should be executed within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

7 4445 14451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. COUNTY a. STATE b. COUNTY St. Mary's Maryland St. Mary's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) NAS, Patuxent River 03 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Hollywood 03 yrs.ll mol. e. IS RESIDENCE ON A FARMS d STREET ADDRESS Rt. #2, Box 280 Station Hospital YES NO X State 3. NAME OF Middle 4. DATE First Year DECEASED OF DEATH August October Marion Greenwell. 67 (Type or print) IF UNDER 1 YEAR IF UNDER 24 HRS B DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED K NEVER MARRIED lost birthdoy) Months Hours Nov. 28, 1923 43 72 hours ofter deoth WIDOWED DIVORCED caucasian male poges land2 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working lite, even if retired)
Aviation Metalsmith Navy U2S. Indiana 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Lillian King (deceased) August M. Greenwell (deceased) 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) within / 13NOV42-160CT67 265-06-0301 Official U. S. Navy Records IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Rupture, liver, massive with interabdominal INTERVAL BETWEEN ONSET AND DEATH in ony event DUE TO exsanguination. Immediate Conditions, if ony, which gave Automobile accident. rise to immediate couse (o), DUE TO stoting the underlying couse o sp 19. WAS AUTOPSY PERFORMED? removol, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) YES NO 200. EXTERNAL CAUSE WAS PRIMARY (A or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) 3 should cremation, or Auto accident. Head-on collision. 20d. INJURY OCCURRED 2 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year While of work of work Street, office bldg, etc.) Hollywood St. Mary's Md. Hour o.m. may be retained for your FUNERAL DIRECTOR: Poge 10:50 p.m. Oct. 21. I certify that I took charge of the remains described above, held on Autopsy X, Inspection X, Inquiry X, and in my opinion deoth resulted from: Natural causes , Accident , Suicide , Hamicide , Undetermined manner CHIEF MEDICAL EXAMINER TO FUNERAL DIRE Heolth prior to b SONSLEE. LT. MC. USN 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER 4 October 16. 1967 17 1) EXAMINER'S TROY D

23C. NAME OF CEMETERY OR CREMATORY Address (Street, city, town, or county) NAME (Type)/ 23d. LOCATION (City or Town) BURIAL CREMATION. 10/20/67 ARLINGTON NATL.CEM. ARLINGTON, VA. 2Sb. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR VR A15ME (5) LEONARDTOWN . MD. -

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH 14453

| | DIVISION OF VITAL RECORDS, 301 W. PREST | ON STREET, BALTIMORE, MARTLAND 21201 | 1 1-00 |
|---|---|--|---|
| FOR STATE | MEDICAL EXAMINER'S | CERTIFICATE OF DEATH | |
| EALTH (DEP (L.) | 1. PLACE OF DEATH o. COUNTY | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residen o. STATE | ce before odmission) |
| 7, ond 3 to PM3. Page, portment of | St MARY'S MARYLAND | VIRGINIA NEWPO | ORT NEWS |
| deloy ond 3 t A3. Pag tment | b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest tawn) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give | neorest town) |
| y d on ortm | NEAR PINEY POINT N/A | NEWPORT NEWS | 83,3 |
| If any of 1, 2, or rm PM. Deportr | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | d. STREET ADDRESS | e. IS RESIDÊNCE ON A FARM? |
| for for | POTOMAC RIVER | 69 REXFORD DR. | YES NO |
| haurs ofter death. If callem 18. Give Pages 1, Office olang with form 1 and 2 with the State De or death. | 3. NAME OF First Middle DECEASED (Type or print) MARVIN LeVAN | JOHNSON 4. DATE Month OF DEATH OCTOBER | |
| s ofter 18. Giv e olang 2 with tth. | S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED | 8. DATE OF BIRTH 11 JAN 37 9. AGE (In yeors lost birthdoy) 30 yrs. IF UNDER Months | Doys Hours Min. |
| F S S | 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ARMY AVIATOR 10b. KIND OF BUSINESS OR INDUSTRY U.S.ARMY | | TIZEN OF WHAT UNTRY? |
| | 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| I within 24 n pencil in Exominer's File pages 2 hours ofte | LEWIS BRAXTON JOHNSON | ANNIE LOUISE STEPHENSON | |
| ed v in II Ex II Ex 72 I | | INFORMANT Address | |
| xecuted nding" ir Medicol permit. | (Yes, no, or unknown) (If yes give wor or dotes of service) Yes 17Mar59-Pres 242522790 U | .S.ARMY | |
| should be executed to word "pending" is on the Chief Medical burial-fronsit permit. | 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).) PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Severe open crush | ing head injury with brain | INTERVAL BETWEEN ONSET AND DEATH |
| ord ord ord ord | 860× DUE TO laceration and co | ntusion and rupture of heart | TENTOTED A WITH |
| the wo to the buriol in ony | Conditions, if ony, which gove (b) associated with a | ircraft accident | INSTANT |
| s certificate should by writing the word forworded to the Ch used os a buriol-transoval, and in ony ev | stoting the underlying couse DUE 10 (c) | | |
| This certificate should be executed within tificate, writing the word "pending" in pencil ld be forworded to the Chief Medical Examine uld be used as a burial-transit permit. File paga or removal, and in any event within 72 hours or | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO Multiple fractures of extremities, crus | | 19. WAS AUTOPSY PERFORMED? YES X NO |
| = 7 = 5 | TO THE POLICE OF THE PROPERTY |). (Enter noture of injury in Port I or Port II of item IB.) decelleration when aircraft cra | ashed |
| fi 33 mile | Hour o.m. While A Not While fo | LACE OF INJURY (Home, form, octory, street, office bldg., etc.) rplane 20f. (City or town) (Co | unty) (Stote) |
| CAL EXAM to execute the for. Page 4 to your CTOR: Page uriol, cremo | 21. I certify that I took charge of the remoins described above, h | | |
| exe exe or. For to the strict of the strict | death resulted fram: Natural causes , Accident x, Su | | |
| JIY MEDICAL ry, please exerting director. P be retained for RAL DIRECTOR prior to buriol, | ACTUAL ACTUAL | CHIEF MEDICAL EXAMINER | 22. DATE SIGNE |
| ITY N Iry, pla eral d be ret be ret RAL D prior | SIGNATURE TO Jogel | DEDUTY MEDICAL EVANIMED | 70 700 |
| ro DEPUTY ME necessary, pleo the funeral dire 5 may be retoi ro FUNERAL DIR Health prior to | EXAMINER'S NAME (Type) WILLIAM D. BOYD, MD | Address (Street, city, town, or county) | OCT 13,1967 |
| necessa the fun 5 moy 0 FUNE Health | 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF | R CREMATORY 23d. LOCATION (City or Town) | (County) (Stote) |
| 0 = 50 H | Burial October 19,1967 Arlington | National | Virginia |
| VR A15ME (5) 6M 1/67 | 24 HOWARD COUNTY FUNERAL Ellicott City, Home of Harry Witzke | | |
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ORIGINALLY REPORTED ON REGULAR DEATH CERTIFICATE AND SHOULD HAVE BEEN M.E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the haspital or attending physician.

CERTIFICATE OF DEATH

| | 1. PLACE OF DEATH O. COUNTY ST. MARY B. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) LEONARDTOWN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) | | | | | | | | | | |
|--|--|--|---|--------------------|---|---|---------------------|--------------------------|--------------------------------|------------------------------------|--|
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| 6 | ST. MARY S HOSPITAL | | | | | d. STREET ADDRESS 6. IS RESIDENCE ON A FARM? YES NOXX | | | | | |
| | 3. NAME OF First DECEASED (Type or print) JOHN | | | Middle | | Last K t NG | 4. DATE OF | Month | | oy Year 2. 19 67 | |
| - 1 | S. SEX | 6. COLOR OR F | | NEVER MARRIED | | DATE OF BIRTH | 9. AGE | (In yeors birthdoy) yrs. | IF UNDER 1 YEAR Months Doys | IF UNDER 24 HRS. | |
| | 100. USUAL OCCU | PATION (Give kind of working life, even if retire) SERVICE | ork done 10b. | | 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? WASHINGTON.D.C. U.S.A. | | | | | | |
| | | | | | | | | | | | |
| IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO. 231-05-1417A FLORENCE B. KING SAME AB # 2 ABOV | | | | | | | | | | | |
| | Conditions rise to imi stoting the last. | if ony, which gove nediote couse (o), underlying couse | BY: E CAUSE (o) DUE TO (b) DUE TO (c) | Inte My Intelli | ò V | ardial & | | neln | 21 0 | NTERVAL BETWEEN INSET AND DEATH | |
| 3 | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO 20d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF FITHER NOTIFY MEDICAL EXAMINED) | | | | | PERFORMED? YES NO | | | | | |
| | 20a. ACCIDI OR CONTRII (IF EITHER, | 20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY CCURRED. (I OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | nter nature af injury in P | ort I or Part II of | item 18.) | | | |
| | 20c. TIME | OF INJURY Month, Doy, our o.m. p.m. | Year 20d. While of wo | e Not While | | OF INJURY (Home, farm, ry, street, office bldg., etc.) | 20f. (City | ar town) | (County) | (State) | |
| | 3011 | 21. I certify that (I) (this haspital) attended the deceased fram 10:12 , 19 (a 10:12 v / , 19 , that (I) (we) last saw the deceased alive an 10:12 v / and that death accurred at 10 M, fram causes and an the date stated abave. | | | | | | | | | |
| | 22c. PHYS | 220. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. DIRECTOR PHYS. DIRECTOR DIRECT | | | | | | | | | |
| 230. BURIAL, CREMATION, REMOVAL (Specify) OCT. 16, 1967 TRINITY MEMORIAL GARDENS WALDORF, CHARKES, M. | | | | | | | | | | ty) (Stote) | |
| 1 | | KE MATTING | LEY LEON | ARDTOWN, MAI | RYLAN | DATE OC | T 1 7 19 | 67 | Cores | Judge | |

DESCRIPTION. ST. MANY ST -1.2 MINOTORANOE! MARINET MARKET MARKET . MARKET HT. HARV'S HOSPITAL COURT Augusta National Street 371:17 JUME 5, 189k CIVIL SERVICE Anti- . . . TERTHEAT RICHNINGS CHANGEER JAMES C. KING 231-03-1917A PLONENCE B. KING CO BAME AS \$2 6 HOVE

BURING COT, 15, 1967 FRINTY MEDICARKE DARBERT MARRIES, UNARGES, MARYGANG MEDICAR DESCRIPTION OF THE PROPERTY O

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14456 14450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STA 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's o COLINTY delay is and 3 ta Page St. Mary's MARYLAND te Department b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PM3. uside RURAL and give nearest town)
USNAS, Patuxent 07 mos. O6days Lexington Park, Maryland River d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) e IS RESIDENCE ON A FARM? d STREET ADDRESS form 130 Chinlee Drive YES NO IX Station Hospital in pencil in Item 18. Give Pages MEDICAL EXAMINER: This certificate shauld be executed within 24 hours after death. ward "pending" in pencil in Item 18. Give Pag the Chief Medical Examiner's Office alang...with NAME OF 4 DATE Year thinke St DECEASED OF DEATH Jr. 196' William Joseph Link (Type or print) October IF LINDER 24 HRS 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF LINDER 1 YEAR 7. MARRIED NEVER MARRIED X lost birthdoy) Months DIVORCED March 4. WIDOWED any event within 72 hours after deoth caucasian male 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR U. S. Naval Hospital. 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Memphis Tennessee 13. FATHER'S NAME Elizabeth Louise Boisclair William Joseph Link Sr. 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service 16 SOCIAL SECURITY NO 17 INFORMANT William J. Link. Sr. same as #2,c & d. 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Asphyxiation IMMEDIATE CAUSE (o) _ e, writing the ward farwarded ta the Ch DUE TO Conditions, if ony, which gove rise to immediate couse (a). ond in DUE TO stoting the underlying couse 19. WAS AUTOPSY to burial, crematian, ar remaval, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION PERFORMED? please execute the certificate, NO Page 4 shauld be 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 3 should PRIMARY | or CONTRIBUTING | CAUSE OF DEATH Found not breathing in baby's crib. 20c. TIME OF INJURY Month, Doy, Year 0:33-hour o.m. OCT 9, 20d. INJURY OCCURRED 2 20e. PLACE OF INJURY (Home, form, (City or town) (County) factory, street, office bldg., etc.) Not While be retained far vaur 5 may be retained far yaur O FUNERAL DIRECTOR: Page Lexington Pk. St. Mary's . Md. ot work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection . Inquiry , and in my apinion / Accident 🔀 Suicide 1 Undetermined manner Hamicide | the funeral director. death resulted from CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Health prior SIGNATURE 10/11/67 ma bon 8 DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) BOYD Address (Streel, city, town, or county) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) T ROY NEW YORK 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE ADDRESS VR A15ME (5) LEONARDTOWN . MARYLAND 6M 1/67

MILE . e'wala .17 t to the second Charles a server of the contract of the contra and the state of t ale landouting to the court of No si contes caman diodexila The state of the s Miles Turke as all the end one can Berein Land State Con Constitution of the State Constitution of the Constitution of th With the party was La property THE PART OF THE PA

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14451 14457 CERTIFICATE OF DEATH within 24 haurs after death 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) funeral o. STATE b. COUNTY o. COUNTY b. CITY OR TOWN (If outside corporate limits, MARYLAND MARY S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b boar papers. Pog within 72 hours write RURAL and give nearest town) filled in by t MADDOX MA LEON A REPORM e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS YES IN NO [MADDOX MARY S NURSTNG HOME RURAL NAME OF First Middle Lost DATE Month Doy Year completely DECEASED 19 67 (Type or print) DEATH OCTOBER ACTIES RUSSELL LYON requires that the death certificate be executed AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED B. DATE OF BIRTH NEVER MARRIED please remake Months Doys Hours and in any WIDOWED DIVORCED CAUCASTAN FEMALE. the attending physician and sit permit. Then please rem 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY HOUSEWIFE DOMESTIC MARYLAND ST. MARY U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, CULLISON RUSSELL FRANK WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service MADDOX Md. NO 579-5044-78 WEST RUSSELL LYON INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit cremat PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO signed t burial, Conditions, if ony, which gove rise to immediate couse (a) DUF TO stoting the underlying couse as the Page 4 may be retained by the haspital or attending O FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) ad far use af Health CERTIFICATION NO X 20o. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) foctory, street, office bldg., etc.) Hour o.m. Not While of work at work 21. I certify that (I) (this haspital) attended the deceased fram shauld 1967 and that death accurred at IEM, from causes and an the date stated above. saw the deceased alive on. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING director, puy M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S MECHANICSVILLE Md. NAME (Type CITYTHER 23b. DATE THEREOF 23d. LOCATION (City or Town) BURIAL, CREMATION, 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) CHRIST CHURCH CEM. 10/4/1967 ST. MARY, S CHAPTICO 2So. REC'D BY REGISTRAR SUNERAL DIRECTOR **ADDRESS** 2Sb. 196 DATOCT LEONARDTOWN MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

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J. J. Trumptom and Jon, Federalaburg, Md.

ARYLAND STATE DEPARTMENT OF I

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212

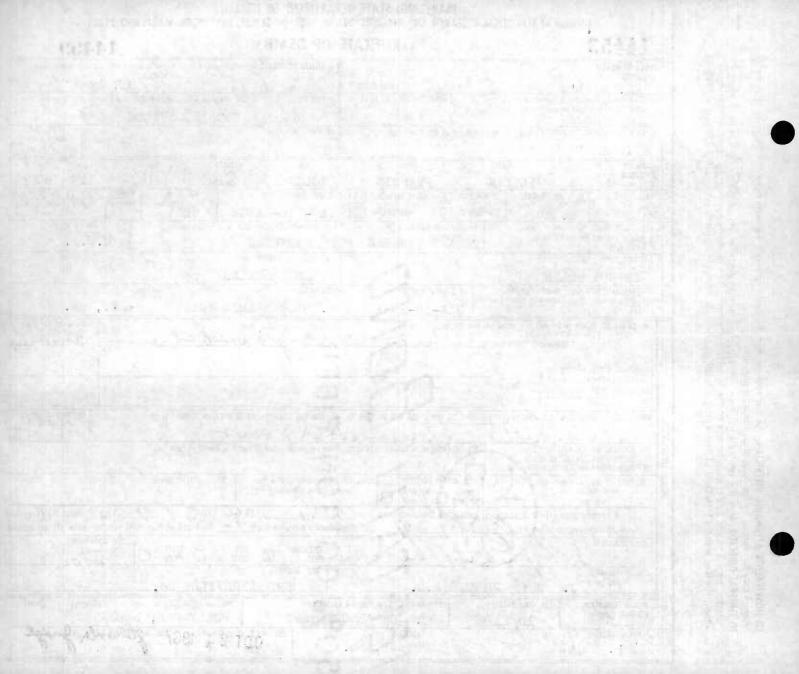
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| | PLACE OF DEATH | | | | 2. USUAL RESIDENCE o. STATE | (Where deceosed lived | d, if institutio b. COUNT | | efore odmission) |
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| | b. CITY OR TOWN I | If outside corporate limi | ts, | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If | outside corporote limit | s, write RURA | L ond give ned | rest town) |
| | LEONARD | d give nearest town) | | | RURAL | MECHANIC | CSVILL | E | 18-1 |
| (| | AL OR INSTITUTION (If n | ot in hospitol, | give street oddress) | d. STREET ADDRESS | | | | e. IS RESIDENCE |
| | ST. MAR | Y'S HOSPITA | AL. | | | | | | ON A FARM? YES A NO |
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| | and the same of | (Give kind of work done | | IND OF BUSINESS OR | | ty & Stote, or foreign co | | 12. CITIZEN | OF WHAT |
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| _ | | | I Mally. | ANT PARELING | | | | 0.0 | • |
| 3. | FATHER'S NAME | | | | 14. MOTHER'S MAIDEN | | | | |
| | ARTHUR | | | | LUCY BU | TLER | | | |
| IS. | WAS DECEASED EVI | R IN U.S. ARMED FORCES? (If yes give wor or dotes | of service) 16. | SOCIAL SECURITY NO. 17. | INFORMANT | | Address | | |
| , | NO | (ii fos giro visi ei acres | 2 | 14-36-2921 | IRS. LEONA N | TARIE NOLA | N V | ECH., | MD. |
| | | EATH (Enter only one co | use per line for | (a) (b), ond (c).) | | 0 | 0 | | INTERVAL BETWEEN |
| | | TH WAS CAUSED BY: IMMEDIATE CAUSE DUI , which gove e couse (o), | | (a) (b), ond (c).) | nonge | mbo | lus | | INTERVAL BETWEEN ONSET AND DEATH CALLEY TO ALLEY |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the haspital ar attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the director, page 3 should be detached far use as the burial-transit permit. Then please remove carbon pipers. Pages should be filed with the State Dept. of Health priar ta burial, crematian, ar remaval, and in any event, within 72 hours also



ORIGINALLY REPORTED ON REGULAR DEATH CERTIFICATE AND SHOULD HAVE BEEN ON M.E.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 1445 | 5 | | CERTIFICA | TE OF DEATH | | 1 | 446) | |
|--------------------------------|--|--------------------|---------------------------|---|---------------------------|----------------------|--------------|----------------------------|
| 1. PLACE OF DEATH a. COUNTY | | | | a. STATE | (Where deceased lived, i | b. COUNTY | | admissian) |
| | MARY,S | | ARYLAND MARYLAND | MARYLAND | ST. | MARY S | | |
| write RURAL a | (If autside carparate limit nd give nearest tawn) | is, | c. LENGTH OF STAY IN 16 | c. CITY OR TOWN (If a | utside carparate limits, | vrite RURAL and g | ive nearest | tawn) |
| LEONAR | | | | RURAL | SCOTLAN | D | | 18-1 |
| d. NAME OF HOSP | ITAL OR INSTITUTION (If n | at in haspital, g | ive street address) | d. STREET ADDRESS | | | e. | IS RESIDENCE ON A FARM? |
| ST. M | ARY,S HOS | PITAL | | SCOTLAND | MARYLANI | | YE | ES NO |
| 3. NAME OF | F | irst | Middle | Last | 4. DATE | Month | Day | Year |
| (Type ar print) | CLARENC | E | HOZIDAR | RIDGELL | DEATH OCTO | RER | 16 | 19.67 |
| S. SEX | 6. COLOR OR RACE | | NEVER MARRIED | B. DATE OF BIRTH | 9. AGE (In | vegrs IF UNDE | R I YEAR | IF UNDER 24 HRS. |
| MALE | CAUC | WIDOWED | DIVORCED | 2-14-1889 | -last birt | hday) Manths vrs. | Days | Haurs Min. |
| IOO. USUAL OCCUPATION | ON (Give kind of wark dane | 10b. KIN | ND OF BUSINESS OR | 11. BIRTHPLACE (County | & State, ar fareign count | | CITIZEN OF V | WHAT |
| during most of working | g life, even if retired) | INC | ARWER | MARYLAND | ST. MARY. | | COUNTRY | 31411 |
| 13. FATHER'S NAME | | | 444 | 14. MOTHER'S MAIDEN | | | | |
| AUSTIN | RIDGELL | | | | | | | |
| | /ER IN U.S. ARMED FORCES? | 1 14 5 | OCIAL SECURITY NO. 17 | REBECCA | HAMMETT | Address | | |
| (Yes, na, ar unknawn) | (If yes give war ar dates | of service) | | | E (2) (2) | | N/ 4 1000FF | 4.000 |
| NO | | | 12-24-2784 | HATTIE L. RI | IDGELL SO | OTLAND | MARYL | |
| 1B. CAUSE OF | DEATH (Enter only one co ATH WAS CAUSED BY: | use per line far i | (a), (b), and (c).) | · 1 de | | | | FAND DEATH |
| | IMMEDIATE CAUSE | (0) Bey | rosardial e | nfarction | | | H | res |
| 4201 | DUE | 10 | 11 | 0 | | | 1 | |
| Canditians, if an | | (b) Chan | natured as | lesqueles | osis | | 6 ge | ars |
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| last. |) | (c) | | | | 267 | | |
| PART II. OTHER | SIGNIFICANT CONDITIONS (| ONTRIBUTING J | O DEATH BUT NOT RELATED T | O THE TERMINAL DISEASE CO | NDITION GIVEN IN PART | 1(a) | 19. W | WAS AUTOPSY |
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| 5 20g ACCIDENT W | AS UNDERLYING | | CRIBE HOW INJURY OCCURRE | D (Enter nature of injury in | Part I or Part II of item | 10) | 11.3 | |
| OR CONTRIBUTIN | G CAUSE OF DEATH | 200. DC | CKIDE HOW WORK OCCURRE | D. (Line) notice of injury in | Ton For Ton II of Hen | 10.) | | |
| | Y MEDICAL EXAMINER) | 001 101 | MIDA OCCIDADES TOO L | DIACE OF BUILDING (I) | 1 2001 (6:1 | \ | C1. 1 | 161 |
| 20c. TIME OF IN | | While | | PLACE OF INJURY (Hame, far) actory, street, affice bldg., etc. | | awii) (i | Caunty) | (State) |
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| | | spital) attend | led the deceased fram. | May 28. | 1967, ta G | ct /6, 19 | 2, tha | it (I) (we) lo |
| saw the | deceased alive an_ | 02 | 16 19 67, and the | hat death a curred at | 1 10 M, from (| auses and an | the date | stated abay |
| 22a. SIGNATUR | | Dlas | Market Ball | ATTENDING | MED. STA | 22b. | DATE SIGNED |) |
| | | MX | m | M.D. PHYS. | DIRECTOR PHY | | 17/6 | 7 |
| 22c. PHYSICIAN | | 200 | | 22d, ADDRESS | MITTO MA | DAL VIND | | The same |
| NAME (Typ | e) P. J. B | EAN M.D | • | GREAT | MILLS MA | RYLAND | | |
| 23a. BURIAL, CREMAT | ION, 23b. DATE TH | EREOF | 23c. NAME OF CEMETERY C | OR CREMATORY | 23d. LOCATION (C | ty ar Tawn) | (Caunty) | (State) |
| REMOVAL Speci | | /1967 | ST. MICHA | EL.S CEM. | RIDGE | | MARY S | |
| 24 FLINERAL DIRECT | 3 // | / | ADDRESS | | D BY REGISTRAR | 2Sb. REGISTRAR'S | | |
| X JOHN M | | FOW A PROT | OWN MARYTAND | | | | | |

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 can should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after depart departs.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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| death. and 2 death. | | LACE OF DEATH | 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence | before odmission) |
| r deat | | COUNTY TO THE TOTAL OF THE TOTA | o. STATE b. COUNTY | 110 4 0 |
| 0 4 0 | | ST. MARY'S MARYLAND | MARYLAND ST. MAF | |
| | | CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give negret town) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give n | eorest town) |
| by the Pages aurs af | | write RURAL and give nearest town) | Hollywood, Md. | 18-1 |
| in ers. 2 h | - | NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? |
| filled in I papers. Thin 72 ha | | ATION HOSPITAL NAS PATUXENT RIVER, MD | Rt#2 Box144L | YES NO |
| pletely fraction of carbon twith | | AME OF First Middle ECEASED FRANCIS F. SMITH | Lost 4. DATE OF OCT 8 | Doy Year 19 67 |
| completel move carbony vent, vent | S. : | M Cau WIDOWED DIVORCED | 3. DATE OF BIRTH Jan 22, 1906 9. AGE (In yeors IF UNDER 1 Y Months D | EAR IF UNDER 24 HRS. ays Hours Min. |
| equires that the death certificate be executed within 24 haurs I physician. signed by the attending physician and completely filled in by the burial-transit permit. Then please remove carbon papers. Par burial, cremation, ar removal, and in any event, within 72 haurs approved St. Mary's County, Md. | IDo. | JSUAL OCCUPATION (Give kind of work done g most of working life, even if retired) rector of vehicles Post Uffice | 11. BIRTHPLACE (County & Stote, or foreign country) Washington D C 12. CITIZ COUN U S | EN OF WHAT |
| ica sic Na Ma | | FATHER'S NAME | 14. MOTHER'S MAIDEN NAME | |
| ling phy ling phy Then removal | | Joseph E Smith | Myrtle E Chapik | |
| ath cending it. The rem | | | NFORMANT , Address | |
| attending permit. The on, ar remo | (Ye | no, growknown) (If yes give wor or dotes of service) 578 07 4700 N | AMA. M. SMITH Same as #2 | |
| that the dan. by the attransit perremation, oved | | 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) | | INTERVAL BETWEEN |
| equires that the physician. signed by the burial-transit burial, crematapproved | | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Aortic | Aneurism | ONSET AND DEATH |
| tra by | | 45 / X DUE TO | | |
| res /sic ned ial, | | Conditions, if ony, which gove) (b) | | |
| physic physic signec burial burial | | rise to immediate couse (o), [DUE TO | | |
| -0, -00 | | storing the underlying couse | | |
| e law ritending as been as the priar ta | | last. (c) | | |
| The se by | IFICATION | PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO T | HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY PERFORMED? YES NO |
| 日本生工生 知 | CERT | 206. DESCRIBE HOW INJURY OCCURRED. (OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | (Enter noture of injury in Port I or Port II of item 18.) | |
| PHYSION PHYSIO | MEDICAL | 2Dc. TIME OF INJURY Month, Doy, Yeor 2Dd. INJURY OCCURRED 2De. PLAC | E OF INJURY (Home, farm, 2Df. (City or town) (Count | (Stote) |
| Q + | MEI | Hour o.m. 19 While Not While of work of work | ory, street, office bldg., etc.) | |
| NDIN ed by After Id be e State | | 21. I certify that (1) (this haspital) attended the deceased fram_1 | 0-8-67 , 19 , to 10-8-67 , 19 | that (1) (we) jus |
| m ~ ~ 5 + | | saw the deceased alive an $10-8-67$ 19, and that | death accurred at 2000 M, fram causes and an the | date stated above |
| OR ATT be retain DIRECTO e 3 share ed with exami | | 220. SIGNATURE | ATTENDING MED. STAFF 22b. DATE | |
| DIRE DIRE DIRE DIRE DE 3 | | M.D. | D. PHYS. LA DIRECTOR L. PHYS. L. 10-0. | -67 |
| May SAL C | | 22c. PHYSICIAN'S NAME (Type) G. J. VUKMER LT MC USN | 22d. ADDRESS STATION HOSPITAL PAX RIVER | MD. |
| HOSP Page 4 Funer director should | 230 | BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR | | ounty) (Stote) |
| Page 4 TO FUN directe should | | Burial Oct 12, 1967 Glenwood Ce | emetery Washington D. C. | |
| VR A15 (4) | 24 | FUNERAL DIRECTOR ADDRESS ADDRESS Hypothesis 110 | 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG | |
| 25M 1/67 | | F. Gasch's Sons Hyattsville, Md. | DATE OCT 1 1 1967 yelland | o judge |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Tuneral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filed with the State Dept. af Health priar to burial, crematian, ar remaval, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 haurs

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14464

4457

CERTIFICATE OF DEATH

| a. COUNTY | ST. MARY S | MARYLAND | 2. USUAL RESIDENCE a. STATE MAR | (Where deceased liv | ed, if institution: b. COUNTY | | | 1) |
|--|---|--|---|---|----------------------------------|--|--|----------------------|
| b. CITY OR TOWN write RURAL of LEO NARD | I (If autside carparate limits, and give nearest town) TOWN | c. LENGTH OF STAY IN 16 | COLTON | _ | its, write RURAL | and give neares | st tawn) | 1 |
| | PITAL OR INSTITUTION (If not in has | | d. STREET ADDRESS | | | | e. IS RESIDE ON A FAR YES N | ENCE RM? NO [2 |
| 3. NAME OF DECEASED (Type or print) | First THOMAS | Middle EDWARD | Last Swann | 4. DATE OF DEATH | Month OCTOBER | Bay | | 67 |
| S. SEX | | RRIED NEVER MARRIED DIVORCED DIVORCED | B. DATE OF BIRTH JUNE 21, 188 | 9. AG | | FUNDER 1 YEAR Nonths Days | Haurs 1 | 24 HR Min. |
| during mast af warking | ON (Give kind of wark done ng life, even if retired) MING | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County | & State, or fareign (| | 12. CITIZEN OF | WHAT | |
| | ILIP BRISCOE SW | | | NAME HATTON H | | | | |
| 15. WAS DECEASED E (Yes, na, ar unknawn | VER IN U.S. ARMED FORCES? (If yes give war or dates of service) | e) | INFORMANT OLGA S.HAN | IER HUG | Address HEBVILLI | E, MARYL | AND | |
| PART I. DI | DEATH (Enter only one cause per I EATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Only, which gove othe cause (a), derlying cause DUE TO (c) | Electral | Taromo | osis | | | ISET AND DE | en |
| PART II. OTHER 20a. ACCIDENT W OR CONTRIBUTION | SIGNIFICANT CONDITIONS CONTRIBL | JEWEL CLE | THE TERMINAL DISEASE CO | INDITION GIVEN IN | PART I(a) | | WAS AUTOF PERFORMED 'ES N | PSY D? IO [|
| | | | | | | | | |
| THE CHIPEK NUMBER | VAS UNDERLYING □ NG □ CAUSE OF DEATH FY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. | (Enter nature of injury in | Part I or Part II a | item 18.) | | | |
| 20c. TIME OF IN | NG CAUSE OF DEATH FY MEDICAL EXAMINER) NJURY Manth, Day, Year a.m. | 20d. INJURY OCCURRED 20e. PLA | (Enter nature of injury in ACE OF INJURY (Hame, far tary, street, affice bldg., etc | m, 20f. (Cit | or tawn) | (County) | (51 | tate) |
| 20c. TIME OF IT Hour saw the | CAUSE OF DEATH FY MEDICAL EXAMINER) NJURY Manth, Day, Year a.m. 19 nm. 19 tify that (I) (this haspital) deceased alive an | 20d. INJURY OCCURRED 20e. PLA While Not While of work at work at work at the deceased from the decease of | ACE OF INJURY (Hame, far tary, street, affice bldg., etc | m. 20f. (Cit | | , 19 67 , th | na (1) (w | /e) l |
| 20c. TIME OF IT Hour Is aw the 22a. SIGNATUR | NG CAUSE OF DEATH FY MEDICAL EXAMINER) NJURY Manth, Day, Year a.m. 19 tify that (1) (this haspital) deceased alive an | 20d. INJURY OCCURRED 20e. PLA While Not While of work at work at work at the deceased from the decease of | ACE OF INJURY (Hame, far tary, street, affice bldg., etc.), at death accurred at ATTENDING D. PHYS. | m. 20f. (Cit | or tawn) | , 19 67 , th | nat (I) (w te stated | /e) l |
| 20c. TIME OF II Hour II Hour II Hour II Hour II Hour II Hour II II Cer saw the 22a. SIGNATUR 22c. PHYSICIAN NAME (THE | CAUSE OF DEATH FY MEDICAL EXAMINER) NJURY Manth, Day, Year a.m. 19 Tify that (I) (this haspital) deceased alive an | 20d. INJURY OCCURRED While Nat While of work at work at work at work and that the deceased from the large and that the man and th | ACE OF INJURY (Hame, far tary, street, affice bldg., etc.) at death accurred at ATTENDING PHYS. 22d. ADDRESS | m. 20f. (Cit | or town) Color STAFF PHYS. | , 1967, the dan the date 22b. DATE SIGN | na (I) (w te stated | /e) lo |
| 20c. TIME OF II Hour I | CAUSE OF DEATH FY MEDICAL EXAMINER) NJURY Manth, Day, Year a.m. 19 1ify that (I) (this haspital) deceased alive an Deceased alive an 23b. DATE THEREOF OCT. 11, 196 | 20d. INJURY OCCURRED While of work of at work of the deceased from | ACE OF INJURY (Hame, far tary, street, affice bldg., etc.) at death accurred at the phys. 22d. ADDRESS ME CREMATORY | MED. DIRECTOR D 20f. (Cit MED. DIRECTOR D 23d. LOCATIC SUITLA | or town) Color STAFF PHYS. | , 1967, the date of the date o | na (II) (w te stated NED D - 67 | re) l aba |

Surrenne, Parmes, Dienes, Mo.

E. MARKE NATERNELEY LEGINORETOWN, MARKEN

SURTAL COT. 11, 1967 CROMA WHILE COMETERY

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CERTIFICATE OF DEATH

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| | | PLACE OF OEATH O. COUNTY | | | | | 2. USUAL RESIDENCE (| Where deceased live | d, if institution: R b. COUNTY | Residence before | odmission) |
| | | ST. | MARY 8 | | MARYLAI | ND | MAI | RYLAND | D. COUNTY | ST. MAR | RYIS |
| | | | (If outside corporate limit | s, | c. LENGTH OF STAY IN 1 | b | c. CITY DR TDWN (If or | utside corparate limi | ts, write RURAL o | | |
| | | LEONARDT | own | | 1 DAY | - | RURAL A | AVENUE | | | 18-1 |
| \ | | | TAL DR INSTITUTION (If no | | ive street oddress) | | d. STREET ADDRESS | | | e. | IS RESIDENCE ON A FARM? |
| 776 | | | MARY'S HOSP | ITAL | | | | | | Y | S NO R |
| | | NAME OF OECEASED | | rst | Middle | | Lost | 4. DATE OF | Month | Ooy | Year |
| | 5. | (Type or print) | 6. COLDR DR RACE | | R. | | OMA 8 | DEATH | OCTOBER | UNDER 1 YEAR | 19 67 IF UNDER 24 HRS. |
| | | | | | NEVER MARRIED | _ | | lost | birthday) Mo | nths Ooys | Hours Min. |
| | | IISHALE | WHITE N (Give kind of work done | WIDOWED | OIVORCED ON OF BUSINESS OR | | EB.5, 18188 | | Yrs. | 12. CITIZEN OF V | MUAT |
| | dur | ng most of working | g life, even if retired) | | DUSTRY | | 11. BIRTHPLACE (County | | | COUNTRY? | MUMI |
| | 13 | HOUSE FATHER'S NAME | WIFE | | | | 14. MOTHER'S MAIDEN | MARYLAND | | U.S.A. | |
| | 13. | | | | | | | | 10.3.3 | | |
| | 15 | | EPH OLLIE L ZER IN U.S. ARMED FORCES? | | SOCIAL SECURITY NO. | 17 11 | MAR) NFORMANT | ELIZABE | TH BALLE | CY | |
| | (Ye | s, no, or unknown) | (If yes give wor or dotes | of service) | | OSE | EPH | | | | |
| | = | In caller of | Nearth /6 | | | | MK M. THOMAS | BAM | E # 2 | | VAL DETAILERS |
| | | PART I. DE | DEATH (Enter only one cou ATH WAS CAUSED BY: | use per line for | Crterio | 11 | 00. 01. | audia | 1600 | DNSS | VAL BETWEEN |
| | | 4221 | IMMEOIATE CAUSE | | in This | A | europe | cour | earle. | 10 | you |
| | | Conditions, if on | | | | | | | | - 1 | |
| | | rise to immedia | | (b) | | | | | | | |
| | | stoting the und | eriying couse | (c) | | | | | | | |
| | | PART II. OTHER S | GIGNIFICANT CONDITIONS C | ONTERBUTING T | O DEATH BUT NOT RELATE | D TO T | HE TERMINAL DISEASE CO | NDITION GIVEN IN F | 'ART 1(o) | 19. V | VAS AUTDPSY |
| 3 | TION | | 2 | lem | le de | 21 | renolia | 7. | | YES | ERFDRMED? |
| | CERTIFICATION | 20o. ACCIDENT WA | | 20b. OE | SCRIBE HOW INJURY OCCU | RRED. (| (Enter noture of injury in | Port I or Port II of | item 18.) | | |
| | | | G CAUSE OF OEATH (MEDICAL EXAMINER) | 190 | | | | | | | |
| | MEDICAL | 20c. TIME OF IN. | JURY Month, Ooy, Year | | | | CE OF INJURY (Home, form | | or town) | (County) | (Stote) |
| | ME | Hour o | .m. 19 | While of work | Not While of work | focto | ory, street, office bldg., etc. |) | | | 1 |
| | | 21. I cert | ify that (1) (this has | pital) offend | led the deceased fro | | | 1966, to (| Sc+7 | 167, tho | |
| | | | legeosed glive on | Och | 6_19/_, and | d thot | deoth occurred of | M, from | n couses ond | on the dote | stated obove |
| | | 220. SIGNATURE | 11/ | , | 6/101 | | ATTENDING 🔪 | MFD. | STAFF 2 | 2b. DATE SIGNED | |
| | | | golf J- | ry | Lacer | M.0 |). PHYS. | DIRECTOR L | PHYS. | 10-10 | -6/ |
| 1 | | 22c. PHYSICIAN' NAME (Type | J. Roy | GUYTHER | M. D. | | 22d. ADDRESS | | 44- | | |
| | | | | | | W 00 1 | | CSVILLE, | | 10 | (5) |
| 1 | | . BURIAL, CREMAT PEMOVAL (Specif | | | 23c. NAME OF CEMETER | | | | (City or Town) | (County) | (Stote) |
| V | | FUNERAL OIRECT | | , 170/ | ADDRESS | EAR | T CEMETERY | O BY REGISTRAR | 2Sb. REGISIR | | , Mo. |
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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1967

MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 4450 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b COUNTY ST. MARY'S 2 3 to Page MARYLAND ST. MARY 'S delay b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) pup PM3. DOA CALLAWAY LEGNARDTOWN e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS ROBAL NO V MARY S HOSPITAL YES in Item 18. Give Pages 24 haurs after death. 3. NAME OF Last 4. DATE Year Day DECEASED (Type or print) DEATH OCTOBER HOWARD LEGNARD WHITE Office alang S. SEX AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE **NEVER MARRIED** 8. DATE OF BIRTH 7. MARRIED last birthday Manths Days Haurs MALE WIDOWED DIVORCED event within 72 hours after death COLORED MARCH 19.1934 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) COUNTRY? Examiner's MARYLAND U.S.A 13. EATHER'S NAME 14 MOTHER'S MAIDEN NAME in pencil This certificate shauld be executed within HOWARD WHITE File ROSE BEALL 17. INFORMANT (Yes, no, ar unknown) (If yes give war ar dates of service) 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address ward "pending" i the Chief Medical 217-28-2853 CATHERINE E. WHITE CALLAWAY. MARYLAND INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: burial-transit ONSET AND DEATH IMMEDIATE CAUSE (a) please execute the certificate, writing the ward director. Page 4 shauld be farwarded to the Ch DUE TO any Canditians, if any, which gave rise to immediate cause (a), = DUE TO stating the underlying cause 0 ond 00 last. WAS AUTOPSY PEREORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) removal, CERTIFICATION NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 3 shauld 20 PRIMARY To or CONTRIBUTING AL EXAMINER: CAUSE OF DEATH cremation, 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF (City or town) (State) Vaur While Nat While FUNERAL DIRECTOR: Page at wark at wark 21. I certify that I took charge of the remains described above, held an Autopsy Inspection ond in my opinion death resulted from: Natural causes Accident / Suicide Homicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** may Health WILLIAM D. BOYD M.D. Address (Street, city, tawn, ar caunty) NAME (Type) 23a. BURIAL, CREMATION. 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 9 BURIAL (Specify) Oct. 14. 1967 HOLY FACE CEMETERY GREAT MILLB, ST. MARY'S 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR VR A 15ME (5)

LEGNARDTOWN. MARYLAND

6M 1/67

W.CLARKE MATTINGLEY

alvea .T. 8 THAN . TO CHAJYAN ALLAJAY MYGYGRAMOZI 1.90 Janiens Lyne .TE CHAMBLE 14475C 19,197 MORA 3 WALE COLORED ABORTA MRYLAND U.S.S. STINI GRAVO MOST BEALL any SIT-CO-2855 CATHERINE E. WHITE CALLADAY, MARYLING 2000 VILLIAM D. BOVO Oct. 1, 1907 Holy Fice Emergey Deskr Hills, St. LARY 18, 5. JAISU V. CLARKE WATTINGLEY LICENARDICAN, ARYGAND

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed fived, If institution: Residence before admission) e. COUNTY b. COUNTY ST MARY'S VIRGINIA MARYLAND NEWPORT NEWS b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporata limits, write RURAL and give nearest town write RURAL and give negrest town NEAR PINEY POINT N/A NEWPORT NEWS d. NAME OF HOSPITAL OR INSTITUTION (it not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? POTOMAC RIVER ADAMS DRIVE, APT YES NO X NAME OF First Middle DATE Month Dey Year DECEASED (Type or print) DENNIS DEATH ANTHONY WROBLESKT OCTOBER 19 67 n 24 hours after death ive Pages 1, 2, and 3 to PM3. Page 5 may be pages 1 and 2 with my event within 72 6. COLOR OR RACE 7. MARRIED X NEVER MARRIED 5. SEX AGE (In yeers | IF UNDER 1 YEAR With 72 IF UNDER 24 HRS. last birthday) Months Hours Min. MALE CAU WIDOWED JULY 40 DIVORCED 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) ARMY AVIATOR U.S. ARMY CLEVELAND, OHIO USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME THADDEUS ANTHONY WROBLESKI HARRIETT DLUZYNSKT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyesgive werar detes of service) 25Aug62-Present U.A.ARMY RECORDS 18. CAUSE OF DEATH [Enter only one ceuse per lina for (a), (b), and (c). INTERVAL BETWEEN INSTANT PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) SEVERE OPEN CRUSHING HEAD INJURY WITH DUE TO LACERATION AND CONTUSION ASSOCIATED WITH ö Conditions, it any, which (b) LACERATION AND RUPTURE OF HEART ASSOCIATED on, geve rise to immediate ceuse DUE TO AIRCRAFT ACCIDENT (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION burial PERFORMED? MULTIPLE FRACTURES OF EXTREMITIES: CRUSHING CHEST INJURIES X NO 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Part II of item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY | or CONTRIBUTING FORCESOF SUDBEN DECELLERATION WHEN AIRCRAFT prior CAUSE OF DEATH. CRASHED MEDICAL 20c. TIME OF INJURY Month, Day, Yaer 20d. INJURY OCCURRED | 20a. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (Stete) factory, street, office bldg., etc.) While Not While Potomac River, St Mary's . Md 19 67 at work at work Airplane 21. I certify that I took charge of the remains described above, held an Autopsy 🗶 . Inspection 🗶 Inquiry 2 and in my opinion death resulted from: Natural causes Accident X Suicide designat Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED or its SIGNATURE DEPUTY MEDICAL EXAMINER NAME (Type) WILLIAM D. BOYD, MD 1967 Address (Street, city, town, or county) Health 22e. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or country) (Stata) REMOVAL (Specify) Calvary Cemetery Cleveland, Ohio Oct 14 '67 Burial 24e. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Howard County Ellicott City, Md Funeral Home of Harry Witzke

MARYLAND STATE DEPARTMENT OF HEALTH

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ICAL EXAMINER: This certificate should be

ORIGINALLY REPORTED ON REGULAR DEATH FORM AND SHOULD HAVE BEEN M.E.,
FILM G394 - 11/15/67 - mnb

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STATE OF THE STATE